



*Congratulations on planning to have  
We are pleased you have chosen*

### Hospital Insurance Coverage

The Insurance Clearance Department will provide information about you and your baby. We ask that you provide information 30 days prior to your expected delivery date.

Be aware that your insurance plan may not cover all hospitalization. If you or your baby are hospitalized, you may be responsible for payment of charges. Please notify your insurance carrier prior to admission and notify your insurance carrier. The Hospital will require you to pay the charges if you do not have insurance. For more information regarding your coverage, please contact your insurance carrier's Member Services telephone number.

Please note coverage and benefit information regarding physician and anesthesiologist fees. **bill may be different.**

Within 30 days after your baby's birth, you will receive a bill from your plan. If the birth is not reported to your plan, you may be financially responsible for the bill.

### Contact Information

Our office is open Monday – Friday

Telephone #: 646 501 3967

Fax #: 646 754 9572

Email: [OBPre Adm@nyumc.org](mailto:OBPre Adm@nyumc.org)

# MOTHER AND BABY QUESTIONNAIRE

## OBSTETRICIAN:

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell #: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Religion: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Tel. #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Legal Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

DOB: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Tel. \_\_\_\_\_